Community-Based Mental Health Initiatives in a First Nations Health Centre: Reflections of a Transdisciplinary Team

Judi L. Malone, PhD
Darrel Stanley, BSW

Abstract

As a case study on collaboration, this paper is a first person account from a psychologist and a social worker and their experiences developing and piloting community-based mental health programs for a rural Albertan Cree community. We provide an overview of two such pilots, the Family Wellness Program and the Community-based Anger Management Workshops. Here we reflect on our attempts to integrate mental, physical, emotional, and spiritual considerations consistent with the community cultural context. Each of these programs have been developed and offered within both interdisciplinary and multidisciplinary contexts involving counsellors, teachers, nurses, and community Elders from within and outside the community. Such dynamic programming has evolved into transdisciplinary community-based mental health initiatives that have enhanced community wellness but also taxed these rural service providers. Together we share our reflexivity, outlining some of the issues, challenges, and inspirations in our separate and collaborative work in our attempts to foster mental health and community wellness for this resilient but marginalized population.

Keywords: collaboration, anger management, community psychology, social work, rural practice, Aboriginal people

The authors wish to acknowledge the traditional knowledge of the Cree people of our area, the teachings we have received from so many wise Elders, the commitment and passion of the Blue Quills First Nations College team, and the literature so effectively articulated by Abadian, Adams, Cashin, Charter, Del Vecchio, Pagans, Poonwassie, Tafoya, Walker, Whitbeck, and others.

Providing culturally responsive clinical services within a community mental health model requires a solid understanding of the social forces and context shaping our lives and the lives of the communities we serve. Key competencies for culture-centred services include: self-awareness, understanding the world view of our clients, using appropriate intervention skills and techniques, and involvement in organizational developments (Arthur and Stewart, 2001). This case study sharing is a first person account of the experiences of two professionals working together as agents of change. With that in mind, we wish to begin with a brief personal placement. Judi is a Canadian woman who lives and works in her lifelong rural community of St. Paul, Alberta. She is an academic and practising registered psychologist who has travelled to work in Frog Lake First Nation for seventeen years. Darrell is a Cree man and proud member of Frog Lake First Nation, a small rural Aboriginal community in Canada. He lives off reserve and travels to his home community to provide services as a registered social worker. We have worked separately and collaboratively in this community. Here, we want to share our experiences developing and piloting community-based mental health programs. We have sought the guidance and permission of community Elders, specifically Francis Quinney and Doris Okanee, who, as gifted helpers and respected Cree Elders, consented to our sharing these stories and encouraged us to publish this article as a teaching tool.

The programs we highlight here arose out of dissatisfaction with existing services which tended to

have individualistic, deficit-based, and treatment-oriented approaches. In our opinion existing programming often lacked full participation even in a community with few resources. Stigma was apparent in community discussions and low attendance could have been related to the focus on "client-only" participation where support persons were not normally welcomed to programs offered. Finally, much of the existing programming was targeted (and funded) for a specific need and unable to be responsive to the myriad of underlying associated issues.

These programs arose in the spirit of community psychology as they have "a more ecological, strengths-based, prevention-focussed approach" (Nelson and Lavoie, 2010, p. 79). We will introduce you to this community and the issues it faces, the community-based anger management and family wellness programs we have piloted, how we seek to collaborate as change agents, and where we hope to take community wellness in this small, rural, Cree community.

Frog Lake First Nation

Alberta has 3 three treaty areas and 140 reserves. Frog Lake First Nation is a Cree band with 2500 members, approximately 1000 of whom live in the community (Indian Affairs and Northern Development, 2010). This remote community, approximately 300 kilometres north-east of Edmonton, is one of beauty and solitude with rolling hills encompassing a small tree-lined lake. The land is rich in oil and gas resources but the community and its members are economically disadvantaged. There is a range of federally funded but locally administered community services with a focus on self-governance (Frog Lake First Nation, 2010). We worked together in the Morning Sky Health and Wellness Centre where most programs are developed and delivered collaboratively between professionals and community members. These authors were the only staff members specifically identified as offering mental health services (Judi as the psychologist and Darrel as the "mental health worker") but we would argue that it is an artificial distinction to separate mental health and physical health. The other programs — addiction counselling, nursing, home care, prenatal, and maternal child health — should all be considered together with the programs that we worked with to offer community health services.

When collaborating with Canadian Aboriginal people to support their mental, spiritual, and emotional health, it is essential to understand their history. Aboriginal people, particularly those living on reserve, continue to suffer disproportionately from poverty, poor health, violence, suicide, drug and alcohol addiction (Abadian, 2000; Walker, 2006). This has been attributed to complicated unresolved trauma (Abadian, 2000; Walker, 2006; Whitbeck et al., 2004) that began with genocidal government policies (Pagans, 2001). This includes a historical loss of social and kinship structures and systemic racism (Poonwassie and Charter, 2001).

> A lack of public infrastructure on reservations compounds the problem with a lack of critical behavioural health services and providers to address this multigenerational holocaust. (Tafoya and Del Vecchio, 2005, p. 55)

Such conditions affect people's coping skills, understanding of social situations, and ability to heal (Abadian, 2000; Struthers and Lowe, 2003).

> Euro-Canadian interventions have not successfully addressed the socio-economic problems experienced in Aboriginal communities as a result of years of colonization. (Poonwasie and Charter, 2001, p. 63)

Knowledge and awareness of multigenerational trauma and the client's specific context is essential. Techniques, sometimes described as "culture as treatment" have been found to be an effective means of countering traumatically induced social pathology (Abadian, 2000). In our experience, many of these are beneficial, particularly: group healing techniques, family involvement, incorporation of spiritual and cultural ceremonies, use of medicine wheels, and story-telling (Cashin, 2001; Pagans, 2001; Poonwasie and Charter, 2001; Romanow and Marchildon, 2003).

Community-based Anger Management

We begin with an overview of our community-based anger management program. Judi works collaboratively with the local National Native Alcohol and Drug Abuse program. Interdisciplinary team meetings often focussed on agency, community, and client pressure for a formalized anger management service. The addiction counsellors saw potential in such a preventative intervention for family relational issues and other addiction-based issues. As a psychologist, Judi is a proponent of the benefits of group therapy and psycho-education groups but questioned the merits of offering a short training to "manage anger."

The original half-day psycho-education session on anger has now evolved into a 2 day program that includes prayer, art therapy, cultural teachings, psycho-education, group sharing circles, and relaxation training. The focus is on identity, multigenerational trauma, power and control, and developing support networks. This ongoing development sequence has included planning meetings, debriefings, and direct collaboration with program participants. Community Elders are frequently consulted and periodically attend the program. Core aspects of the program integrate physical, mental, emotional, and spiritual aspects of anger with a focus on wellness rather than pathology consistent with our understanding of local Cree cultural teachings. Transportation and food are provided and the training takes place at a neutral community location with time balanced between indoors and out, in conversation and in activity, in sharing and in teachings. This program, ongoing for three years, is offered four times a year. Participants complete written evaluations at the end of the program and other professionals are invited to attend both to participate and to provide consultative evaluations on the program itself.

This program is now offered monthly with growing acclaim (and demand) from within and outside of the community. Some community members have attended the program several times and espouse the benefits of ongoing wellness training. Most participants sign up voluntarily based on word of mouth recommendations. Judi has been pleasantly surprised by how this program continues to evolve with community and participant collaboration and is happy that she has learned more than she has shared.

This program has also been taxing. The other program leader is also the only male NNADAP counsellor who has a mandate to provide intervention and prevention of addictions in a community rife with alcohol and drug abuse. Common themes in addiction services have been the high unemployment rate, chronic alcoholism in older males, and a growing number of youth abusing drugs. There are high levels of reported cannabis abuse but even higher rates of reported crack cocaine, cocaine, and ecstasy abuse in addition to alcohol abuse and dependence. Judi only comes to the community twice weekly and there is often a waiting list for her services. Time spent planning and offering these anger management sessions means days where no individual or crisis services are available from either of these providers. Large numbers of referrals from other programs raises questions of responsibility for service delivery and its associated costs. Judi feels torn between providing a service that makes a real difference and is becoming truly "owned" by the community and working outside the scope of her contract. If successful, such programing could mean reduced individual or crisis services in the long term. Several participants have taken the program more than once indicating benefit from such group-based services. Ideally, we would like to monitor the number of crisis and individual service requests comparing times when there were group programming available and prior to it being offered.

Present concerns about the utility of this program is outweighed by the inspirations received from this program to date. In one offering there were only six male participants, most of who have been implicated as aggressive, high-risk resident drug dealers. All indicated that participation in the anger management program was only to avoid breaching probation and being reincarcerated. The facilitators employed additional safety procedures carefully constructed and debriefed during the training including measures for confidentiality, extra clarification of roles, and choosing a private yet accessible setting. The final art works done by these participants were colourful, symbolic, and presented with deeply reflective statements about power, racism, rational thinking, and personal responsibility.

Uncharacteristically, hugs and tears were shared as day one's art was ceremonially burned. One of the older participants asked to lead the closing prayer which began long after the program was supposed to have been finished. Leaving the facility, Judi heard the men discussing how they will structure their own support group. In the final debriefing, the program leaders agreed that they had originally been apprehensive about working with this group. Together we shared some of the teachings we received — rather than what we gave — to this group.

Family Wellness

Next, we want to share our experiences with the Family Wellness Program. Darrel, the co-author of this paper, was in a new role as the community mental health coordinator. He worked with a community member and teacher who has the role of maternal child health coordinator. This coordinator had expressed concern that most of the mothers she deals with are teens and that she had effectively integrated Elders into the community program but could not engage the young fathers. Darrel had strong relationships with the community youth based on over a decade as a trusted school counsellor. Together they devised a Family Wellness Program — an unfunded collaboration between their programs.

The structure of the existing parenting program allowed for workshops, crisis intervention, and support to single mothers that might have had outside referrals facilitated by the mental health coordinator. This evolved to include a family wellness component that directly involved Darrell. This development incorporated cultural teachings, Elder support, psycho-education, group sharing circles, and regular home visits and individual counselling sessions. There was more focus on identity, self-care, and relational health rather than strictly parenting. The program's aim evolved to empower rather than to teach. The maternal health coordinator focuses her individual and group efforts on the mothers in the program. Darrel's involvement went beyond psycho-education groups to include individual and group work with the fathers in an attempt to engage them in family processes as fathers and men with a focus on both the responsibilities and joys of this role. Together they acted as co-counsellors offering couple counselling to these young parents to balance perspectives and focus on larger relational concerns. Community Elders acted as consultants and attended various sessions within the program teaching, sharing, and supporting these young parents. The school supported students who are in the program by providing program flexibility and other agencies refer parents in a progressively more preventative way. This program ran for two years with groups meeting once to twice monthly. Participant evaluations were completed orally with the nursing staff assigned to the mothers in the program.

Such dynamic programming enhanced community wellness by taking focus off "at-risk young mothers" and shifting it to ways that the community could collaborate to foster and strengthen the families of the future. Darrell, a dedicated father, was able to share his own parenting successes and fears in ways that inspired his own parenting while role modelling for the young parents in the program who often see child rearing as typically done by mothers or grandparents rather than by both parents.

One of the more taxing aspects was justifying Darrell's time. His involvement meant a direct service role rather than the expected coordination role, lessening his availability for community and crisis concerns. Additionally, the maternal child health program has had so many referrals that interdisciplinary collaborations with other members of the health centre (including Darrell) most often occurred over lunch hour or otherwise outside of working hours. Crisis management — rather than coordination — frequently interfered with scheduled activities. We worried that program instability within the health care environment may have meant risk to program sustainability if program leaders left their current roles and that such changes could foster transference issues if they were seen (in a culturally appropriate way) as parent figures. It is with sadness that we acknowledge that before this article went to publication funding for Darrell's position was abolished and the program reverted back to the original maternal child health program.

The primary inspiration for the program leaders had been teenage parents reporting effective communication strategies and sharing successes and support with their peers. Given the high teenaged birthrate in the community, these program participants could be future leaders and role models in a significant way. It is our hope that they continue to benefit from community support despite the sudden and premature termination of the Family Wellness Program.

Collaborating as Agents of Change

There are many forms of collaboration in professional practice. In our work we have interagency relationships where we collaborate with professionals of varying disciplines from other agencies such as teachers, social workers, counsellors, and nurses for program ideas and referrals. Each of the pilot programs that we have described also involved multidisciplinary teams where members cooperatively provided discipline-specific contributions. Judi has contributed as a psychologist, and Darrell as a social worker. Our initial successes followed interdisciplinary collaboration which is "the deliberate pooling and exchange of information and knowledge that crosses traditional disciplinary boundaries" (Crossley et al., 2008, p. 231). Collaborating in this way allowed us to begin to address the complex, multifaceted problems we faced and to set goals for achieving common ground (Austin et al., 2008; Van Vliet, 2009). Such professional interactions are an effective way of providing for an integrated community response (Bock and Campbell, 2005; Donoghue et al., 2004). In our work this meant taking time to meet and advocating for these kinds of expanded roles.

What has been most successful, in our experience, has been our evolving transdisciplinary work. This is when we have collaborated in ways that evolved beyond discipline-specific contributions (Austin et al., 2008). Transdisciplinary collaboration exceeds the level of integration typical in most rural and remote collaborations and in our case has been evolving specifically to a community approach towards mental health and wellness. It is this level of community psychological practice that resulted in the two pilot programs highlighted in this paper. Our work really started to move to this level as a result of visionary commitment from several community addiction counsellors, flexibility in Judi's contract with the federal government, and a commitment from the Health and Wellness Centre that resulted in Darrel being appointed in a full time role to oversee mental health needs in the community. In this capacity we collaborate with each other, our clients, community members, and Elders to consider mental, physical, emotional, and spiritual considerations for community wellness. In this way we work with and for the community.

Policy Considerations for Transdisciplinary Collaboration

The literature speaks to the benefit and potential of transdisciplinary collaborations (Fuqua et al., 2004; Pohl, 2008; Stokols et al., 2008). Policies supporting transdisciplinary community-based collaboration have proven benefits for health promotion, intervention, and prevention programming. Further, transdisciplinary collaboration allows enhanced service delivery and can improve organizational climate for service providers. Such policies not only foster these collaborations but help to maintain focus on the cultural and community context, provide a foundation for practice guidelines, and foster better evaluation of initiatives (Fuqua et al., 2004; Stokols et al., 2008)

Specifically, it is suggested that transdisciplinary applications serve to inform culturally and contextually relevant policies for service provision (Pohl, 2008). With ongoing changes to policies and funding structures this becomes progressively more important (Fuqua et al., 2004; Stokols et al., 2008).

It is our hope that these case studies, and our experience, serve as phenomenological data to inform such research and policies. From our perspective, we have learned that rural, remote, and close-knit communities benefit more from collaboration, community-side involvement, and shared roles and services then from "cookie-cutter" approaches to programming. When service providers are able to consult Elders and each other they may be, as was the case for us, more able to creatively serve community needs.

Moving Forward

Although inspired (and exhausted) with our present work, our vision is to continue to collaborate beyond the scope of our "jobs" or "professions" for community wellness. We have experienced success from the interventions noted in this paper but recognize two significant considerations. First, development and implementation of such dynamic programming has been a taxing process. We both work in evidence-based practice funding and program models, in an area of extreme need where one always has to justify time spent planning rather than providing direct services. Second, we are sadly aware that we have only just begun to scratch the surface of what can — and should — be done. Working without additional resources, reaching out to the needs of the community as a whole, and ensuring cultural appropriateness raises new questions on a regular basis.

There have been gains. Both of the examples cited in this paper have full participation and word of mouth referrals are ongoing. Funding for supplies and refreshments remains a struggle as does justifying the time required to offer group initiatives — let alone plan on empirically investigating their benefit. But, this is only the beginning. We have been discussing ways of delivering a community-specific and culturally appropriate version of Assertive Community Treatment teams for those with significant mental illness. These people tend to be the most marginalized in the community and neither existing supports nor punitive interventions have demonstrated any benefit to those with mental illness or their families. Our hope is to collaborate in ways that ensure those with such significant mental health needs are supported within community networks and can benefit from cultural inclusion. The benefits of transdisciplinary support is certain to better support these community members and those who will work directly within these teams.

Discussion and Conclusions

Aboriginal Canadians are a considerably disadvantaged minority group. The majority of Canada's Aboriginal People live in rural areas (Romanow and Marchildon, 2004), are isolated from services, and have higher rates of unemployment (Bollman, 2007; McIlwraith and Dyck, 2002). Ethically, we must take into account the needs of both client and community and find a balance between professional and community standards (Schank and Skovholt, 2006).

In this paper we have shared two examples of our transdisciplinary collaborations that have demonstrated community success and rewarded us as service providers. Although we lack empirical evidence for the success of these programs we see these interventions as promising. There is a need for ongoing study on culturally appropriate transdisciplinary applications. We also suggest that policy review is in order to facilitate more creative community-based programming. For now, however, we offer these reflections in the spirit of sharing and with a commitment fostering mental health and community wellness as a personal and social responsibility.

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Judi L. Malone is a registered psychologist. She works in the areas of professional ethics, rural practice, social justice, and interdisciplinary collaboration. Recent publications in 2012 include "Professional ethics in context: Practising rural Canadian psychologists." *Journal of Bioethical Inquiry, 9*(4), 463-477, and "Ethical professional practice: Exploring the issues for health services to rural Aboriginal communities." *Rural and Remote Health, 12*(1), 1891.
Judim@psychologistsassociation.ab.ca

Darrel Stanley, BWS is a registered social worker at the Morning Sky Health and Wellness Centre, and a member of the Frog Lake Cree Nation.
darrellpstanley@gmail.com